Lincoln Financial critical illness insurance FAQ

Key questions and scenarios

1 **Q: What is critical illness insurance?**
A: Critical illness insurance provides a lump-sum benefit paid directly to you and can be used to help offset the direct and indirect expenses associated with living with a condition, such as a heart attack, stroke, cancer, major organ failure, or other medical events. It protects in times of financial and emotional stress associated with the critical illness. The benefit does not coordinate with any other coverage and is not dependent upon the actual cost of care.

2 **Q: What is a critical illness qualifying event?**
A: A qualifying event or initial diagnosis by a licensed physician must occur on or after your effective date. Additional criteria may be required depending on the condition being diagnosed.

3 **Q: I'm in treatment for cancer; am I eligible for benefits if I sign up for critical illness?**
A: Benefits under this plan are based on the timing of the initial diagnosis of a condition — so the initial cancer diagnosis needs to be on or after your effective date to qualify for payment. So, if you have been in treatment for some time for a cancer diagnosis before your effective date, no cancer-related benefits would be payable, though you would be eligible for payments for other covered conditions that may occur.

4 **Q: I've had a stroke; what is required for benefits to be payable?**
A: Stroke is defined as neurological damage to the brain due to inadequate blood flow in any of the cranial vessels due to either blockage or rupture of the vessel. It can be diagnosed via imaging (like a computed tomography (CT) scan or magnetic resonance imaging (MRI)) and examination noting neurological deficits that must be present for seven days or more. This can include blurred vision or loss of balance. Transient ischemic attacks (TIA) are not covered under this plan.

5 **Q: What is needed to get a payout under the health assessment/wellness benefit?**
A: You need to provide the type and date of the qualifying test/exam and the name of the physician or facility where the test/exam was done. However, these types of claims don't require additional medical documentation and can be submitted by phone or through our online portal.

6 **Q: What if I have critical illness coverage and my company already offers cancer coverage?**
A: For new cancer diagnoses that occur after your effective date, employees enrolled in both coverages can receive benefits from both plans. There is no offset to Lincoln's critical illness coverage — so employees can receive the enrolled lump sum from the critical illness benefit and ongoing treatment coverage payouts from their cancer plan.

7 **Q: I had a suspicious mammogram; would that qualify for this benefit?**
A: Mammograms alone are not enough for a payout of the critical illness benefit; you'll need to have a biopsy completed to confirm a cancer diagnosis to receive a payout under the plan.[1]

8 **Q: I had a biopsy that confirmed cancer, but they haven't completed staging yet. What benefit am I eligible for?**
A: If a cancer has not been confirmed as invasive or non-invasive at the time of the claim, Lincoln will provide the payout at the lower non-invasive coverage level. If additional staging determines that the cancer is invasive, Lincoln will then issue the additional benefit payable for that condition above and beyond the non-invasive benefit already paid.

9 **Q: What's the difference between invasive and non-invasive cancers?**
A: Non-invasive cancers are malignant cells confined to the surface tissues and without spread to lymph nodes or other tissues. Invasive cancers are those with uncontrolled growth beyond the initial tissue. Leukemia that is above stage zero is classified as an invasive cancer. Diagnosis must be by a board-certified oncologist or pathologist.

[1] If a Pathological Diagnosis is medically inappropriate or life-threatening, a Clinical Diagnosis of Cancer will be accepted instead.

10 **Q: What is an occupational disease?**
A: Incidence of the covered conditions (hepatitis, human immunodeficiency virus (HIV), methicillin-resistant Staphylococcus aureus (MRSA), rabies, tetanus, and tuberculosis) that result from documented accidental exposure in the workplace. Diagnosis must be confirmed by testing relevant to the disease and an accident report must be filed at the workplace. Only the employee is covered for these conditions.

11 **Q: What if my condition reoccurs?**
A: If you have a new diagnosis related to a previously paid condition but have gone more than six months treatment-free, you're eligible for a new payment under the plan.

12 **Q: What if I have multiple conditions?**
A: If you're diagnosed with a new unrelated covered condition more than 12 months after a previously covered diagnosis, you can also receive payment for the new diagnosis.

Preexisting conditions

13 **Q: Are there any preexisting condition exclusions?**
A: Yes. Preexisting condition exclusions apply to critical illness coverages.

Eligibility

14 **Q: How long can I cover my children under this plan?**
A: Children can be enrolled in the plan until they reach age 26. Children lose coverage at the end of the month in which they turn 26.

15 **Q: When can I enroll in this benefit?**
A: You may enroll yourself or your dependents for this benefit at three points:

- Within 31 days after becoming eligible for coverage
- During the company's annual enrollment period
- If you experience a qualifying life event such as marriage, birth of a child, adoption, or change in employment or eligibility status for yourself or the dependent spouse

16 **Q: What if I'm leaving my company? Can I take this plan with me?**
A: Employees who leave the company or retire under age 70 can apply to take the critical illness coverage with them. This application must be started within 31 days of leaving the company.[2]

Claims questions

17 **Q: Is direct deposit available?**
A: Yes. Direct deposit or check are both options for benefit payment. Note: Direct deposit is available for health assessment benefits claims submitted online.

18 **Q: Where do I submit claims?**
A: Claims forms are available at LincolnFinancial.com and can be submitted online, by mail (The Lincoln National Life Insurance Company, P.O. Box 2609, Omaha, NE 68103), or email FileClaim@LFG.com. Employees may also report claims by phone at 800-423-2765 or fax at 877-843-3950.

19 **Q: What happens after I submit a claim? When should I expect to hear from Lincoln?**
A: Your assigned case manager will review the claim within three to five business days after the claim submission. If we need additional medical information, Lincoln will contact you. If information isn't supplied with the claim form, you'll be asked to complete an authorization to release medical information form so that we can request your treating provider(s) to supply Lincoln with the applicable records for your claim. We'll contact you if we need additional medical information. In some cases, if an authorization to release medical information is on file, we'll also make a request to your treating provider.

[2] Employees may continue their coverage under the port option until the greater of age 70 or 12 months.

Premium questions

20

Q: What does “attained age” mean?

A: Attained age is your age as of your effective date anniversary each year. Employees will change age brackets the plan year after the birthday that moves them into a higher age bracket.

21

Q: How are premiums calculated?

A: Premiums are per $1,000 of elected coverage and are based on 0-year age brackets. To get the number, take the face value of the elected coverage and divide it by $1,000. Then multiply that amount by the rate for the age bracket you fall in as of your effective date anniversary of the prior year to get the monthly benefit amount.

22

Q: Is there a waiver of premium available for this coverage if an employee is disabled?

A: We allow the premiums for critical illness coverage to be continued if the employee is totally and continuously disabled due to a covered critical illness for more than six months. Premiums must be paid during that six-month waiting period. After that, if the employee is approved for a waiver of premium, the coverage can be continued for two years as long as the employee remains disabled.

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